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THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 7
DECEMBER 1985-JANUARY 1986

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HAMPDEN DISTRICT MEDICAL SOCIETY 1985-1986 SEASON

District Meeting

PLACE:	Springfield Marriott Downtown Springfield
DATE:	Tuesday, January 28, 1986
BUSINESS MEETING:	6:00 p.m.
SOCIAL HOUR:	7:00 p.m.
DINNER:	7:30 p.m. Spouses are welcome
SPEAKER:	John J. Coury, Jr., M.D. President-Elect American Medical Association
SUBJECT:	"AMA Update on Major Issues"

NOTE: If you must cancel your dinner reservation, please call the office before noon on January 28th. If the cancellation is not made, you will be BILLED for your dinner.

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THE HAMPDEN HIPPOCRAT

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DECEMBER 1985 — JANUARY 1986
VOLUME XXXXII NO. 7

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D., and William A.R. Chapin, M.D.

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HDMS President's Message

Augusto G. Asinas, M.D., President

The Medical Society and its leadership is thankful to those physicians who took time from their busy practices to participate in and be present at the hearings for the medical malpractice issue, both in Springfield and in Boston. It is essential that we continue our quest and fight for the fair treatment of physicians by the elected officials of our state, and most of all by the legal profession. The time has come for us to enlist the support of our patients, and express our deep concerns for the future of health care. Recently you all received from the Massachusetts Medical Society a petition and a request for the signatures of our patients and friends on this petition. If you have not begun to circulate this petition, please do so.

I find it very difficult to understand why we are expected to come up with great sums of money to pay for ever escalating and skyrocketing insurance premiums for medical malpractice insurance when we cannot pass these increased expenses through to our patients because of the laws preventing balance billing for Blue Shield and placing a freeze on our Medicare fees. To add to this problem the Governor recently signed into law an act that conditions medical licensure upon mandatory acceptance of Medicare reasonable charges as full payment for all services of physicians who treat Medicare patients. All of these actions by our state government have placed a great financial burden on the physicians who are trying hard to practice good medicine in spite of cost cutting, while supporting growing families and responding to expectations to participate in community charitable endeavors.

The Governor has just now realized that there is indeed a medical malpractice crisis in our state and that this will greatly impact on the health care system. He has introduced legislation designed to reform the malpractice system. Unfortunately, this will not address the high premiums that we expect to pay soon.

It is essential, therefore, that a freeze be considered on our premiums at this time while the Governor's proposal is studied very carefully. I urge everyone to participate in the deliberations by contributing monetarily and continuing the effort to keep the pressure on our legislators for this reform. Only then can we be assured of preserving the future of private practice of medicine.

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MMS Auxiliary, President's Message

Anna Ferguson, President MMS Auxiliary

To me the Hampden District Medical Society Auxiliary has always been synonymous with Service. For the past two years I have had the priviledge of attending your annual meeting and installing your officers. Each time, I have been impressed both with your accomplishments, and with the warmth and cordiality of your members.

It is difficult to choose any one of your accomplishments over the others--annual health seminars, scholarships to students in medically related fields, programs at the Springfield Science Museum--TAM, Kits on the Heart, the Lung and Smoking. It is obvious that you enjoy your work and are meticulous in the preparation of these programs.

Heretofore, it has been only Hampden District that has benefited from your acheivements, but now the entire state will do so from your "As I Live and Breathe" kits which are in great demand statewide. You have set a precedent that will be very difficult to surpass, but I am as certain, that as night follows day, Hampden District Auxiliary will do so.

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Medical Malpractice: Who Speaks For The Victim?

Much attention has been given to the impact of medical malpractice upon physicians, lawyers and insurance companies. The victim has been obscured, if not entirely forgotten, by the system that is designed to compensate him when he has been treated by a physician who is judged guilty of malpractice in a court of law.

The victim is victimized by the most expensive legal system in the world. A patient [plaintiff] who "wins" a malpractice lawsuit can expect to receive less than thirty cents of each dollar paid for malpractice insurance by physicians. In addition, he will wait an average of four years to have his day in court. And his chances of "winning" are less than 50%.

When a verdict favors the defendant physician, the patient's lawyer suffers a double loss: he earns nothing since his fee is contingent upon a percentage [one-third to one-half] of the damages awarded to his client. He actually loses money by virtue of time spent on the case and the expenses paid by him in developing the case for trial. The physician loses time and income from his practice. The physician's insurance carrier has spent a considerable amount to defend him.

"Win" or "lose," the victim may have to suffer years of loss of income, emotional stress and frustration before he goes to court. This is a curious paradox since malpractice suits have been based upon injury allegedly resulting from delayed treatment by physicians.

The current legal system for handling malpractice cases is under fire from lawyers, court justices and prominent educators. Smaller claims may not be accepted by lawyers because the prospective award does not make it economically feasible to pursue the case. Hence, the availability of legal service is intimately tied to monetary factors. In defense of the contingency fee arrangement it is said that it provides legal service for those who cannot afford it. However, lawyers have always supported the concept that legal service should be available to all regardless of ability to pay. Out of this concept they created the "Public Defender." The Public Defender must deal with life and death issues and this is certainly no different in malpractice law.

Therefore, we propose that a "Malpractice Prosecutor" program be created by legislative action, and that this program posses the following objectives:

1. To provide expert legal service with free choice of lawyer to all regardless of ability to pay and regardless of projected monetary reward.
2. To reduce the burden that society bears for the excessive cost of litigation.
3. To provide victims of malpractice with full, undivided compensation which is fair and appropriate.
4. Compensation for lawyers serving indigent clients should be keyed to reimbursement levels of the Medicaid program for physicians and paid by the state. While operating expenses are not factored into Medicaid payments to physicians, consideration could be given to doing so in respect to certain costs incurred by lawyers in preparing for trial.
5. Non-indigent clients would pay usual and customary legal fees. Contingency fee arrangements should be considered illegal and unethical as they are in other major democracies of the world.
6. A ceiling on awards should be set at $300,000. The court may be petitioned for larger amounts in cases presenting special circumstances. Decisions regarding additional awards should be made by the presiding judge.
7. Malpractice insurance should carry a $300,000. limit. Coverage should be compulsory for all physicains.
8. Awards in excess of $300,000. would be paid by a Victims' Fund created by setting aside twenty-five percent of the receipts received in a single year by the state lottery. Citizens of our commonwealth spend approximately $90,000,000. annually purchasing lottery tickets. Hence, about $22,000,000. would be channelled into the fund in one year and would be self-sustaining due to the interest earned.
9. Expert witnesses should recieve no compensation beyond travel expenses which would be paid by the court from the above fund.
10. Out-of-court settlements should be a matter of public record.

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11. Countersuits by physicians against plaintiffs' lawyers should be barred.

The advantages accruing from such reforms of the systems are:

1. Lawyers would not be placed at financial risk which occurs in the contingency fee arrangement.
2. The potential dollar value of a malpractice claim would not determine its litigation potential. This would be based soley on the merit of the claim. Consequently, the screening of malpractice claims by lawyers would be done with such a high degree of skill and intensity that the Malpractice Tribunal [which now screens all cases] would be unnecessary. Its elimination would save time and money.
3. The poor would have equal access to the finest legal talent.
4. As cost-effective medicine has evolved, so would cost-effective legal service evolve. Lawyers would be motivated to carefully utilize resources inrepresenting plaintiffs.
5. Mandatory malpractice insurance coverage would eliminate the problems encountered when physicians who elect to practice without such insurance are sued.
6. Malpractice insurance will again become available at a realistic cost. This will reduce the hidden cost of "defensive medicine," eliminate the adversary atmosphere which is creeping into physician-patient relationships, and return doctors to "doctoring" instead of "risk management." It will reduce early retirement of skilled physicians whose experience is irreplaceable but who cannot continue practicing under the economic burden of current malpractice insurance rates.

The foregoing are not the only issues which require reform. The concept of punitive damages, the statute of limitations for claims, and other elements which perpetuate the staggering costs of the system remain to be revised.

Here again a paradox emerges wherein we are waging war upon escalating costs of medical care while we ignore the price we pay to compensate those who are injured by such care.

Every major societal reform has resulted from an aroused citizenry seeing the need for change and taking action. And it is, after all, the citizenry across our commonwealth who have a truly vested interest in this problem. ■

Manoel Rodamilans, M.D.
Allen Shepard, M.D.

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Medicine Through The Years

by Margaret, Stoler, Springfield Academy of Medicine

In conjunction with the 1986 Physician Portrait Fund Drive, a series of articles will appear in the Hippocrat giving an overall view of the development of medicine from the colonial period to the present.

1786-1836

Epidemics of yellow fever and small pox still plagued the colonies through the eighteenth century, particularly in the seaport cities. As early as 1647, Boston had established quarantine regulations. Philiadelphia first felt the rage of yellow fever in 1699 and New York in 1702. By 1793, the death rate attributed to yellow fever in Philadelphia alone was 4000. Dr. Benjamin Rush, one of the most prominent physicians, wrote:

> "Most people who could fled the city...Of those who remained most were afraid to venture on the streets....Those who ventured abroad had hankerchiefs or sponges impregnated with vinegar or camphor at their noses....The corpses were carried to the grave on the shafts of a chair, the horse driven by a negro...unattended by a friend or relative & without any sort of ceremony....The old custom of shaking hands fell into such general disuse that many were even affronted at even the offer of a hand."

There was great controversy as to whether yellow fever was imported or manifested itself locally. Some believed it eminated from putrified coffee which was frequently left on the wharfs through neglect. The usual treatments of purging, cupping and bloodletting were administered.

In 1819 a young physician, a former student of Dr. Rush's, Dr. John Sappington, purchased an extended tract of land along the Mississippi River. He hired two French botanists to study cinchona bark which he knew the Indians had been using to fight fever for many years. The botanists isolated quinine and the first quinine factory was established in Philadelphia in 1822. By 1832 Sappington began manufacturing quinine, himself, and in 1844 published his "Theory and Treatment of Fevers" in which he described in detail the method of preparing "Anti-fever Pills."

At the same time, great strides were being made in the treatment of smallpox. Though Dr. Edward Jenner is usually credited with being the discoverer of the vaccination in 1796, there is substantial evidence that a farmer in Yetminister, England, by the name of Dorset Jesty, was the first to become aware of the relationship between cow pox and smallpox when he noticed that two of his milkmaids who contacted cow pox did not contact smallpox while administering care to those most severely afflicted with smallpox. In 1774, Jesty scratched his wife and two sons with a darning needle and rubbed the wounds with a cow pox pustle. Though he never published his discovery, he was awarded a set of gold needles from the Royal Society of London.

In 1785 an English medical practitioner wrote the following:

> "I never heard of one having...smallpox who ever had cow pox. I have now inoculated 60 persons who have been reported to have had the cow pox & I believe at least 40 of them I could not infect."

Yet it was Edward Jenner in 1798, upon submitting his paper on vaccination, that received the highest honor from the Royal Society of London for his discovery of cow pox vaccination.

In America it was Dr. Benjamin Waterhouse who was the first to recieve a supply of the cow pox substance in 1799. He gained permission from the Boston Board of Health to inoculate nineteen orphan boys, then send them to live at Noodles Island, an isolation hospital. After twenty days of exposure none contacted the disease.

There was, of course, a segment of society, the "Anti-Vaccinators" who claimed through pamphlets that "infecting humans with a cattlle malady had caused men to bellow like bulls and women to grow hair." By 1802 cow pox vaccine was being used in all the major seaports in America. Since 1949, there has not been a single case of smallpox reported throughout the United States.

Though he strongly disapproved of vaccination and continued to bleed, purge, blister and cup, Dr. Benjamin Rush cannot be discounted as one of the major contributors to the field of medicine during this period. It is estimated he taught over 2300 students as Professor of Medicine at the University of Pennsylvania. He was a proflific writer and many of his theories were practised several decades after his death in 1813.

Rush's greatest contribution was his recognition that mental illness was disease. In 1789 he strongly recommended to the Trustees of Pennsylvania Hospital that a separate building be erected for the mentally ill so they would not disturb those convalescing; that they be provided with closed chamber pots to lessen "the sufferings of persons in a small room," and that feather beds and hair mattresses be made available and that they be treated with dignity, "free from moral stigma." Though many of his recommendations were acted upon immediately, the Philadelphia Hospital for the Insane was not erected until 1841.

Rush held with Pinel that insanity did not always involve the intellect; some patients reasoned well but became "the involuntary vehicle of vicious actions through the instrumentality of their passions." Though his approach to mental illness was far advanced, his recommended treatment parallel-

Continued on next page

Medicine Through The Years

Continued from previous page

ed those used as torture in much earlier times. Rush's "Tranquillizer (sic) Chair" held the head in a fixed position and retained the patient until the blood drained from the brain thereby releasing the tension until the patient was sufficiently tranquilized. He also believed in ice cold showers to bring the patient back to reality. Is it any wonder why a large portion of society welcomed any treatment that was not painful or disabling. The time was ripe for change.

The sucess of quacks: there were the "Grahamites," those followers of Sylvester Graham who claimed illnesses were aggravated by poisonous drugs such as calomel, that a diet of natural vegetable foods and abundant use of whole wheat flour would assure a healthy body as well as disposition. Thus today we have on every market shelf, the Graham Cracker. Samuel Thomson, Father of "Thomsonism," believed disease was due to excessive coldness in the body. Hot baths and strong herbs were the answer. He published several books and established "The Friendly Botanic Society" in Columbus, Ohio in 1834. His following was so strong that two Botanic-Medical Colleges were established in the 1830's, one in Columbus and one in Tennessee. A schism developed within the organization causing a decline in the whole Thomsonian movement, through "secret remedies" containing only vegetable compounds can still be purchased at health food stores today.

One of the earliest and most successful "quacks" was Elishe Perkins who was born in Norwich, Connecticut in 1741. He was educated by his father, Dr. Joseph Perkins. In 1796 he demonstrated his "Metallic Tractors" to the Board of Managers of the Almshouse in Philadelphia who were so impressed they purchased the patent immediately. The tractors were two small metal rods, one brass and one steel, which were drawn downward over the affected area of the body for a period of twenty minutes. By 1800 Tractoration was completely refuted by the medical profession and Perkins was expelled from the Medical Society of Connecticut. He took his metal rods to Europe, was hailed as miraculous in London, and in 1804, his son established the Perkinian Institute there.

One of the strongest and most influential movements for change was Homeopathy. The major doctrine was that "Like cures like-that God created plants in a form suggesting that organ upon which they act, i.e. walnut shells for head injuries; yellow turmeric for jaundice; powdered mummy for prolonging life..." They also promoted the theory that medicine administered to a healthy patient would produce symptoms similar to those of the disease to be treated; thus a healthy patient would take a series of medications so their reactions could be observed and a record of their responses kept. Homeopathy received a great deal of public support resenting the campaign forged by orthodox doctors to pressure the state legislatures not to license homeopaths, but the campaign failed. The first homeopathic hospital was built in Philadelphia, the Hahnemann Hospital. By 1902 there were twenty two homeopathic schools but their popularity declined, and by 1927 only two still existed.

Homeopathy did force orthodox medicine to re-examine their medical colleges and to weed out those graduates who deserved little more respect than the quacks.

Ironically, while orthodox medicine in the East was in the throes of quackery, the physicians living in frontier settlements were making remarkable discoveries quite by accident. Dr. Ephraim McDowell, born in Virginia in 1771, educated at Edinburgh, began practising in 1795 in Danville, Kentucky. He made calls on horseback within a perimeter of sixty miles. He preferred to perform surgery on Sundays when most of the villagers were at church and there would be little chance of a crowd surrounding the kitchen table when the surgery was performed.

In 1809, McDowell examined Mrs. Jane Crawford, mother of eight, who was pregnant with what she though were twins. Having felt no movement and now entering her eleventh month, decided to contact McDowell. She rode on horseback to which a small platform had been erected to carry her extended abdomen. The following day McDowell removed a diseased ovary which contained a twenty pound tumor. Ten days later, Mrs. Crawford was up and making her own bed, requesting that she be allowed to return home. Throughout the next twenty years, McDowell performed twelve ovariotomies with only one fatality.

Since publishing was frowned upon at this time as being "unprofessional," it wasn't until two years later that the following letter written to his nephew, a practicing physician in Philadelphia, was published:

"I told the lady I could do her no good..that opening

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the abdomen to extract the tumor was inevitable death...If she thought herself prepared to die I would take the lump from her....I opened her side & extracted one of the ovaria which from its diseased & enlarged state weighed upward of 20 pounds; the Intestines, as soon as the opening was made run (sic) out upon the table, remained out about 30 minutes & upon Christmas Day they became so cold that I thought proper to bathe them in tepid water previous to my replacing them. I then stitched up the wound & she was perfectly well in 25 days."

Not until five years after the surgery, did his eastern peers begin to take seriously the ovariotomy. In 1824, Dr. James Johnson editor of the *London Medico Chirurgical Review* wrote; "He could not possibly imagine an abscure surgeon living in the backwoods of America could become a pioneer in a new branch of surgery." Three years later, he published an apology, claiming "There were circumstances...that raised misgivings in our minds for which we ask pardon of God and of Dr. McDowell of Danville."

In 1879 a monument was erected in honor of Dr. McDowell, the first to be erected honoring a physician in America.

Another major pioneer was Dr. William Beaumont, an Army physician based at Fort Mackinac in Michigan. He had the unique opportunity to observe the digestive processes in a young Canadian Indian who was accidentally shot in the left side. After applying a poultice of flour, hot water, charcoal and yeast, the wound healed except for a small fistula. Fortunately it was just large enough for Beaumont to observe digestion. After several experiments, the patient ran away to Canada and lived to be eighty three years old.

Beaumont sent samples of the gastric juices to Yale College for further study and eventually published "Experiments and Observation on the Gastric Juice and the Physiology of Digestion."

There were, of course, numerous other achievements in the field of medicine during this period such as John C. Otto's account of a family of "bleeders" resulting in his discovery of hemophilia; Hezekiah Beardsley described in a paper congenital hypertrophic pyloric stenosis for the first time and Dr. Elisha North published "A Treatise on a Maligant Epidemic, Commonly Called Spotted Fever," which gave the first adequate description of meningitis. These are only a few of the accomplishments made during this period.

At last, medicine was moving foward.

UPDATE ON THE PHYSICIANS PORTRAIT FUND DRIVE 1986

The total amount donated thus far is $1,625.00. Our goal is $3,500.00. WE NEED HELP. A CHECK FOR $5 or $10 FROM EACH MEMBER OF THE SOCIETY WOULD QUICKLY REACH THE GOAL, SO PLEASE SEND YOUR DONATION TODAY TO

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H.D.M.S. MEETING

"Current Problems of Massachusetts Physicians"

Massachusetts Medical Society President Barbara Rockett,M.D. was the featured speaker at the Nov. 19th HDMS meeting, and those assembled heard a well organized, no-nonsense action plan for the many concerns that cloud the practice of medicine.

Dr. Rockett, in the first 6 months of her term, has organized a brand new, experienced legislative team that has met problems squarely and intensively. The Workers' Compensation bill will take physicians' fees out of the Rate Setting Commission in addition to its other needed reforms. Generic drug prescribing, nurse practitioner, and physician bills have been resolved satisfactorily so far.

Outlining the history of the State Law S.217 which ties medical licensure to mandatory acceptance of Medicare "reasonable charge" as full payment, she told us of the Mass Medical Society's planned lawsuit seeking an injunction against implementation of the act. 93.9% of Massachusetts physicians already accept Medicare assignment as opposed to 65% nationwide!

Professional liability problems remain on the front burners, and despite Gov. Dukakis proposals, the MMS will continue to push its own as well. Long term cures and short term remedies are both needed, with the reins put on rate increases and a "compensation fund" accumulated by insurors.

The MMS is bidding to become the State-wide PRO, she reported, with good efforts being made so far.

Public relations programs, consumer education and public surveys are underway. Substance abuse in athletes and students is under attack by the Society as well. Discipline of peers is being attended to, she reported, but strangely enough, legislators deny the funds needed by the Board of Registration in Medicine to do this adequately.

Dr. Rockett impressed the group as having done an admirable job on all counts thus far. The MMS has been "on top" of the issues, using negotiation whenever possible and confrontation when necessary. She gave a final plea for us to enlist support from all areas-hospitals, business leaders, allied health professionals, and our patients.

W.J. Baker M.D.

Pictured at the November District Meeting are (left to right) Drs. Walthall (Secretary) Asinas (President) Rockett (MMS President) and Slachta (President-Elect HDMS).

Its My Turn

Discounting: Margin vs Market Share

It is in vogue today to talk of alphabet soup; that is, HMO's, IPA's, PPO's and other alternative health care systems, as new and innovative ways of providing health care to millions of Americans. As medicine leaves the cottage industry stage of its development, as small farms relate to agribusiness, we must have an understanding of how a small businessman can relate to the changing trends. It must be done without destroying the principals of quality care and service to the community and it must be done without destroying the practitioner's ability to earn and protect his or her family and economic wellbeing. The problem with big business is that it often has an impersonal face and cuts an indiscriminate swath as it rolls on with never-ending appetite for expanding market share and increasing margins of profit.

We as physicians have been asked, cajoled and often intimidated by hospitals and insurance companies to discount our fees to maintain market share in the ever shrinking medical economy. We have often responded out of fear of competition from ourselves as well as the fear of the ability of some insurance companies to bring in outside competition (closed-paneled HMO's). We deserve the benefit of some good business sense. First, one can discount only for a limited period of time if one cannot control his cost of doing business. If one has limited assets to provide a service or sell a product below cost to temporarily develop an increased market share, failure is inevitable. Certainly, if you can provide a large volume of service or goods at a discounted price you will be able to remain solvent. In the service industry of medicine, however, there is limited productivity based on physical ability, time and varied patient expectations. But we are really used to making the every day decisions of margin-versus-market decisions when we expand our practices, add additional hospitals to our market and agree to decreased margins to join insurance plans as preferred providers or contract physicians.

So why is it so critical for us as providers of medical care in our community to be careful now. We are now faced with a squeeze that has made our ability to control the cost of doing business impossible. We are faced with potentially skyrocketing malpractice premiums that may be retroactive. We are faced with increased rents in a now speculative real estate market. We are faced with increased costs of running our offices with salaries to employees and cost of supplies. We are faced with the inability to pass on the increased cost of doing business because of relationships with Blue-Shield, Masterhealth Plus, Medicare and Medicaid. The private insured patient cannot pick up the burden of cost shifting. We are faced with slowdowns in reimbursement by third parties to improve their cash flows at our expense. Some of us are borrowing to stay in business. Many of us have taken substantial cuts in income over the last several years.

We have come to a period of time where, for some, margin cannot be reduced and adequately be compensated for by increased market. We as physicians in Massachusetts rank 41st in the United States in income and this is obviously skewed by the higher earning power in the Eastern part of the state. Many are in no position to reduce margin any farther.

Physicians must also realize that the insurance industry desires profitability that is earned by margin and market share. It is very competitive. Many desire to get into this market place; this is healthy. It should bring down the cost of insurance to our community from those companies that desire to be competitive by increasing their market or entering into a new market.

What it should not be is increased profit by decreasing the cost of doing business by discounting reimbursements below the cost of doing business or result in cost shifting to our other patients. I personally support those plans that wish to pay a fair fee with guarantees that when the cost of doing business increases so does the reimbursement. The insurance industry's margins of profit and increased marketshares should allow them to profit in the marketplace. It will be difficult for physicians to subsidize these profits under the current economic situation. If insurance plans cannot be profitable with increased marketshare in this depressed marketplace, perhaps they do not belong here. If we do not approach discounting in this manner, our patients will ultimately suffer in Western Massachusetts with decreased availability of routine as well as high risk specialty care as physicians leave the area. We will then find out if there are too many physicians as the Government suggests or too few to provide the quality care the citizens of this community deserve.

Gregory A. Slachta, M.D.

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How to Know a Good Medical Malpractice Case

In this article, originally prepared for a legal audience, a prominent New York City plaintiff's attorney sets forth the guidelines he follows when an aggrieved patient asks him to take on a medical-malpractice case.

The best time to make a detailed analysis of a medical-malpractice case is before suit is undertaken. If you wait to learn at trial that there is no liability or that there is a strong defense, you will have wasted a great amount of time and money. We have come to recognize that without substantial damages and proof of proximate cause, the plaintiff's lawyer will come to grief. No one wins when a $100,000 case is compromised for $10,000.

Beyond these fundamental considerations, however, lie some methods of distinguishing the potentially good case from the bad one. Two of these are to analyze the motivation of the client to sue, and to analyze those facts that either bend a case toward better chances of winning or bear the seeds of destruction.

CLIENT MOTIVATION

More than in any other field of litigation, in a medical-malpractice case the motivation of the client is crucial to the outcome of the suit. It's inevitable that juries look to the plaintiff's underlying emotions to help decide liability and to set damages in these cases. Motivations also predict how well you and the client will get along, and whether the client will ever be satisfied with the case, no matter the outcome. If you hear a prospective client say any of the following things, watch out.

"Those butchers killed my dad. Now I want to get them." Though human, the revenge motive is particularly bad justification for a suit. This client wouldn't be happy even with the doctor's electrocution. You have to explain that tort-damages suits are not established to seed revenge. I suggest you say that most doctors treat lawsuits as a cost of doing business and turn the matter over to the lawyers hired by their insurance company. When the case is settled, it is the insurance company that pays. The doctor is not punished, and if he wins he has the last laugh.

"I really don't care about the money. I want to sue to prevent other people from having to go through what I went through." This is an unpromising motive. You must explain that lawsuits don't clean up the medical profession, even assuming there is something generically wrong. A client like this is not going to be happy with the suit, because he is not going to find in your conduct of the case the social benefits he thought would be there.

"The doctor has sued me for his $800 bill. I want to counterclaim for all he's worth." This is the person you should stop at the door. If this client had a good case, he would have seen a lawyer before the doctor sued on his unpaid fee. The jury is going to perceive what is in fact involved: a cheap client who doesn't want to pay the bill.

"Please put my case into suit. The statute of limitations runs out in five days." An interview will usually reveal that this person has been to see many lawyers, all of whom have turned down the case, but who, considerately, have told the prospective client when the statute will expire. The odds are overwhelming that the case is not a good one. If you show any interest, you may be in the position of having to file suit in a rush—and then seeking to be relieved from it by the court.

"I want you to take over my case. My first lawyers were a bunch of bums." Beware. If you think that you will appear to be any better than the client's last lawyer ("He would never call me back. He was abusive. He probably sold out to the doctor's lawyers."), you have a lot to learn.

"I had a bad result. It must have been the doctor's fault." I don't know how many times I've tried to explain to angry clients the difference between liability and damages. Most of them don't want to understand. Telling a seriously injured person that there must be a proximate relationship (I use the term "bridge") between his injuries and some departure on the part of the doctor goes in one ear and out the other. Yet if

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no relationship exists, there's no case, and the client should be turned away.

"I rang the call button all night, and no one responded." This client should never have gotten in for an interview, but if he is there, you say, "And then what happened?" Replies the client, "You don't understand. What if something *had* happened?" This client has to be taught that malpractice means both fault and injury.

"I still like Dr. Smith. He was our family doctor for years. But my children keep telling me I should sue." This client lacks the staying power for a long malpractice suit. A person has to have some anger and let it show at the proper time. After a while, complaisant clients will tell you they want to forget the suit.

"I want you to sue Drs. Jones and Bones, but please leave Dr. Smith out of this. He was nice to me in the hospital." This client sends two shivers down my spine. First, these are decisions that are ultimately for the lawyer to make. Second, leaving out one defendant will lead to the sued defendants ganging up on the unsued one after the statute has run out. It is essential to have control over the case. If that can't be accepted, then the client should look elsewhere for a lawyer.

"I had this tumor for three months, and the doctor didn't discover it was cancer." Cancer supercharges an already emotional malpractice case. Most of these unfortunate victims are really complaining about the bad cards fate, so the anger is transferred to the doctor. Sometimes the doctor has delayed improperly in diagnosing and treating cancer, with proximate damages. But often the doctor's delay was minimal, at most, and not the cause of what followed. If the doctor is being blamed irrationally, you know who's next in line to be blamed.

"Nobody knows how I suffer. My life is destroyed." I don't want to be cynical about this client, because one hears this most of the time. The injuries caused by malpractice, be they big or small, do devastate some clients. These people live in pain; their lives are abruptly changed. But if these whiners make a bad impression on you, won't they turn off the jury, too?

Unlike some of my other hypothetical clients, the whiner is one you ought not reject. Even though you know you'll have continuing personality problems, you owe him representation. After all, it's likely that pain contributes substantially to making him as he appears to you. It's up to you to make the jury understand that a personality change is yet another injury inflicted by the doctor's negligence. "Lightly he bears his client's cares" would be a good saying for every plaintiff's malpractice lawyer (and perhaps for every lawyer) to put on a wall. It might serve to remind us all that we're getting paid to care, as well as to produce results.

What then, I can hear you asking, makes a good client? Here's my ideal client talking: "I really don't know if this is a malpractice suit or not. I know I've been injured, but I have to leave it up to you to find out whether the doctor is liable. If you find there is a basis for suit, please sue the parties you think are responsible. Meanwhile, I'm going to try to return to work, even without my right leg." (By the way, I'm still waiting for this person to come to the office.)

NEGATIVE FACTORS

After you've analyzed the motive of your prospective

Continued on next page

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How to Know a Good Medical Malpractice Case

Continued from previous page

client, the next step is to assess the negative and positive factors of the case. Here are some elements that portend a poor legal prognosis for a plaintiff's lawyer.

Cosmetic surgery. "I wanted a nice-looking nose, and I suppose it's better than it was, but it's not what I had in mind." This is a case every experienced lawyer would flee from and so will a jury. A juror with some unflattering physical characteristic may think, "I've learned to live with it. He got what he deserved." It makes little difference if there is some medical reason for the surgery, and it was not done just for vanity.

The dentist. The reason he pays low malpractice rates is that he usually wins at trials. Juries just don't seem to care about other people's teeth and gums, and they tend to believe that the second dentist, who charged $10,000 to fix up a mess that the "bad guy" dentist made, is no more to be believed than the first.

The psychiatrist. He enjoys virtual immunity (with the exception of sleeping with patients) because there is no standard by which a possible departure may be gauged. How can a jury find that but for improper psychoanalysis, my client would have been less mentally ill today than he is?

Injury to the genitals, anus, intestines, or feet. Like the mouth, these are parts of the body that jurors seem to be uninterested in, if not outright offended by. If a jury must decide for the plaintiff, it tends to bring in small damages. And I don't think we need Freud to tell us why, either.

A sick person who gets sicker. For example, a 90 year-old man with terminal cancer has a FOOB (a fall out of bed). Yes, this is wrong but it is more an indignity than a situation that will evoke damages from the injury. When the case comes to trial, long after the person is dead, the event will seem trivial.

Delay in diagnosis of cancer. Many cancer cases lack merit because there are no damages proximately related to the fault. At one end, the person may have lived several years after the tumor was finally removed, with no metastasis. What are the damages occasioned by the delay, if any? At the other end, the testimony may be that the spread had seeded itself before the primary tumor was detectable, again raising the issue of the extent of damages. Many cancer cases are meritorious, but more than in any other area, they call for lining up the expert before the suit is started.

Cancer is incorrectly diagnosed. "They cut half my buttock because they misread the slide and said it was a malignant tumor." When the jury learns it was only a benign tumor

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that could have been locally incised the predictable reaction is that the plaintiff should be thankful it wasn't cancer.

Infection in the incision. To lay persons, having an infection develop in the would after surgery is obvious malpractice. We know however, that the usual nosocomial infection is unaccompanied by any fault on the part of the doctor or hospital. Of course, there may be a delay in diagnosing the infection, but the usual case is going to be a loser.

Hepatitis following a blood transfusion. This is an injury without a remedy. Usually there is no fault, and few states impose strict liability.

Lack of informed consent. It was a great battle won when the plaintiff's bar obtained judicial recognition of the duty of doctors to inform their patients about the risks of, and alternatives to, proposed procedures. But a cause of informed consent almost always loses. This is because the jury believes that a reasonable person (using the objective standard) would have consented even if he had been told of the specific risk that came to pass. In contrast, an informed-consent cause of action joined with one for negligence is often a winner: If the doctor wants those known risks of surgery, then why didn't he warn about it?

Multiple defendants, all of whom made the same error. Sometimes the same mistake—for example, failure to make the correct diagnosis—was made by a series of doctors over time. If enough doctors make the same mistake, they tend to create for a jury their own standard of care. "How simple could it have been to make this diagnosis if so many doctors missed it?" jurors will ask. While more defendants provide more pockets from which to obtain a settlement, the better case is one-on-one.

The defendant doctor is from central casting. He looks as if he stepped out of a Norman rockwell painting. He is kindly and sincere. The jury may overlook his look of medical knowledge and find it very difficult to bring in a verdict against him.

The case was so good I didn't need to hire an expert. Famous last words. Beware of res ipso loquitur.

POSITIVE FACTORS

Brain-damaged babies. Juries are unusually sympathetic to infants injured during delivery or soon thereafter. These cases tend to involve devastating injuries and some want of care on the part of the doctor, often in delaying a Caesarean section. Lawyers call these capital cases, and not just because they are first-rate. They are also amoung the hardest, because the lawyer must know as much about obstetrics as a doctor does.

The plaintiff is in a coma, in a vegetative state, or is blind. Jury sympathy is strong, and damages are large because a considerable amount of special damages can be demonstrated.

Injury to eyes, face or heart, or the presence of scarring. These are the kinds of things to which juries pay close attention.

The doctor was outside his field. He was, for example, trying to treat an infection that should have been handled by an infectious disease expert, but he wanted to keep the patient with the gynecological staff.

The doctor is not a physician, or is practicing in a cultist area. For example, he is a podiatrist, or a chiropractor, or "into holistic medicine." The plaintiff can manage somehow to hold this defendant's conduct to a higher standard set by a physician specialist.

A healthy person goes in for a test and comes out injured. Such developments, while little more than "bad results," do motivate a jury to make an award because of the surprise nature of the injury.

Changes made in records, or lost records. If you take on a case where the doctor or the hospital changes something in the records, you will need less than the unual quantum of fault to prevail before a jury. The same is true if a record or X-ray is missing. Even a change that the doctor argues was made in good faith or a record lost with an explanation ("fire," "flood," and "robbery" are the big three) will suggest to the jury that there was a guilty motive afoot—and there probably was.

The doctor is arrogant, aloof, hostile, or coldly impersonal. This type of doctor, although he may be a medical genius in the laboratory, will not sell well to a jury.

Another type who gives the defense counsel shudders is the foreign medical-school graduate who speaks and writes broken English. It's not nice to comment on ethnic matters, but note how happy the plaintiff's lawyer is when the defendant is "Dr. Patel," the radiologist from Baluchistan.

WORDS OF CAUTION

Plaintiff's lawyers probably err on the side of taking bad malpractice cases. We all have had the experience of wondering at trial what we ever saw in the case. Some 65 to 80 percent of malpractice cases are lost at trial, according to various national studies. The time to gather the records, consult the expert, and think hard about the coming months is at the outset of the case. If the anticipated fee is not going to cover the hours and the expenses you'll be putting out, it takes only a little courage to turn down the case, no matter how egregious the wrong seems to be.

One last word of caution on how to turn down cases. If there has been personal contact with the prospective client, and especially if some investigation was done, the practice of "defensive law" calls for a letter to the client (some send it by registered mail) in which it is made clear that you are not going to handle the case, setting forth reasons. Don't say that it's not a good case; you don't know that. State that you don't want to handle the case, but that you're not the last word. There may well be other lawyers who would start suit on these facts. And do your best to inform the person of the applicable statute of limitations.

If I had followed my own advice consistently over the years, I would be writing this from St. Moritz, but it so happens I am in my office in New York, still trying to profit from prior mistakes.

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Unneeded Tests, Procedures Inflate Medical Costs

CHICAGO--Medical costs can be best reduced by eliminating unnecessary tests and procedures, according to a report in the *Journal of the American Medical Association.*

The report suggest that a major and rapidly growing component of medical care costs stems from widespread application of tests and procedures that have no demonstrated benefit and may even be harmful.

"Identifying and curtailing such unnecessary medical care, rather than rationing beneficial technologies, should be the thrust of cost-containment efforts," asserts Marcia Angell, MD, deputy editor of the *New England Journal of Medicine.* She groups unnecessary care into three categories: "little-ticket" items such as x-ray films, which often have no indication and no benefit to the patient; "big-ticket" items, such as coronary bypass surgery, which may not be indicated for as many as 25 percent of those currently undergoing surgery; and aggressive treatment of terminally ill patients.

"Last year, in a large teaching hospital in New York, 10 percent of the hospital budget was spent on the final admissions of the 4 percent of patients who died in the hospital," Angell says. She notes that nearly half of these patients had diagnoses of cancer or other terminal disease. "Treating these patients much less aggressively and directing the treatment toward their comfort would in most cases be kinder, and it would secondarily result in very large savings," she observes.

Angell estimates that these three categories of unnecessary medical care represent a cost of more than $15 billion per year in the United States. In contrast, certain expensive, lifesaving medical procedures cost less as a whole. If heart transplants were performed on all patients who needed them, the cost per year would be about $7.5 billion; and for liver transplants, less than $1 billion. The idea of rationing is contrary to the physician's role as a patient advocate, Angell observes, and it is based on the false premise that more is better. "Cost containment should be seen as a matter of directing funds and services away from unnecessary care and toward beneficial care, even though the unit costs of the letter may be high," she says.

There is a large "gray area" between lifesaving procedures and unnecessary ones, Angell says, calling for much more effective technology assessment. "The data concerning the indications and medical risks and benefits of many of these procedures and practices are simply inadequate," Angell observes. "In the absence of data, the tendency is to act rather than refrain from acting."

Expenditures for unnecessary medical care are an inherent and growing part of the medical care system, Angell says. She proposes three methods to reverse this trend: revise fee schedules so that they neither encourage nor discourage the use of tests and prcedures; undertake systematic studies to assess technologies and practices, and make every effort to discourage the practice of defensive medicine.

We Have Someone To Care

Homemaker-Home Health Aide Services

The Visiting Nurse Association of Springfield, Inc. (V.N.A.S.), has been serving the communities of greater Springfield since 1914. During this period, the V.N.A.S. has sought to identify, and consequently meet the very special needs found to exist in these neighborhoods.

The Homemaker - Home Health Aide component of the V.N.A.S. services has provided a unique type of caring for the past twelve (12) years. These services were intitiated in direct response to the increased need for a supportive form of care that would satisfy the patient's personal care and home management needs.

The specific services utilize Home Health Aides - Homemakers - Personal Care Homemakers - and Respite Care Workers. Their responsibilities include, but are not limited to: bathing, grooming, planning and preparing meals and the maintenance of a clean, safe patient environment accomplished through homemaking tasks such as cleaning, laundry, shopping, and the completion of errands.

The paraprofessionals, employed by the V.N.A.S., are certified under the guidelines outlined in the Massachusetts Department of Public Health, and are in full compliance with Medicare/-Medicaid regulations. All cases assigned to a paraprofessional team member are carefully supervised by a V.N.A.S. professional.

The V.N.A.S. Homemaker-Home Health Aide staff is currently comprised of over one hundred and fifty (150) caring and compassionate individuals, committed to the people they serve and the job they do. The V.N.A.S. may not always have enough of these special people to meet the ever increasing demand, but it does employ the very best.

A member of one of our patient's families submitted a note not very long ago concerning the services provided by a V.N.A.S. Home Health Aide. We'd like to share it with you:

> Frankly we can only speculate as to what my mother's truthful current condition would be were it not for the service provided by Helen. Her efforts are professional and reveal real dedication. She is a highly qualified, motivated, and cheerfully efficient representative of your excellent staff.

If you find that this form of service would be of value to your patients, or if you would like additional information, please contact the V.N.A.S.' Central Intake Unit at (413)781-5070. All services are available twenty - four (24) hours a day, seven (7) days a week.

Diane Gonyea, R.N.
Program Development and
Community Education Supervisor

The successful "Getting to Know You" Cocktail Dance, sponsored by the H.D.M.S. and the Auxiliary was held November 1, 1985 at the Yankee Pedlar Opera House. Seen here enjoying the evening are (left) Dr. & Mrs. Gus Asinas, President, HDMS and (right) Dr. & Mrs. Gus Siragusa, President-Elect of Mass. Medical Society. □

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Notes and Quotes of Interest

One of the really good things of medical interest happening these days in Springfield is *Health Care for the Homeless,* a program started over two years ago by nurses Sister Julie Crane, Sister Joan Roche and Ruth Conner. They continue to try to minister to the physical needs of Springfield's homeless people and visit the shelters, soup kitchens, Salvation Army, and other special places where the homeless gather. Physicians have helped in this program and these women thank all of you for your support.

The homeless comprise the highest portion of untreated illness in America. In addition to mental illness, trauma is common, along with respiratory and circulatory disorders. Infection commonly finds its way among these people as well. TB screening, flu shots and pneumonia shots are also being carried out and all of these efforts, thanks to all involved, are increasing in scope and effectiveness. Keep up the good work, we say!

The Putnam LPN Program is looking for donations of out-of-date PDR's that might be otherwise discarded. Please call Joan Breitung, RN at 787-6763 if you have a 1980 or later PDR to donate.

The Springfield Health Department has need of an otoscope for use in its Well Baby Clinic. Perhaps a retiring physician would consider donating this instrument. Call Anna Kopec, RN at 787-6736.

Dr. Ingrid Schweiger, a psychotherapist in Longmeadow and an advertiser in these pages calls our attention to the fact that each year 400,000 tenagers try to end their lives and that 6,000 succeed. She is planning a nationwide suicide prevention program for teens, parents and professionals, and is also planning a television documentary on the subject. For more information, she can be reached at 567-3133.

The members of the **Board of the Medical Auxiliary,** especially the **Scholarship Committee,** wish to express heartful thanks for your generous contributions to the Auxiliaries Scholarship Fund Drive.

Those who continue to give year after year, and to new contributors, we extend to you our deep appreciation for your support.

It has been through you, that for over 30 years, we have been able to give out in our community, scholarships to qualified, needy students entering the health fields.

Again, a big thank you, from all of us, for your continued support.

Lorraine Penhos
Scholarship Chairperson

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February 10, 1986	"Respiratory Therapy: Uses and Abuses"	Joseph Zibrak, M.D. Instructor in Internal Medicine, Harvard Med. Schl., Director of Respiratory Therapy, New England Deaconess Hospital
March 10, 1986	"Lymphoma"	Mark S. Huberman, M.D. Instructor in Medicine, Harvard Med. Schl., Attending Physician, Section of Medical Oncology, New England Deaconess Hospital.
April 14, 1986	"Malnutrition: A National Problem"	George Blackburn, M.D., Assoc. Professor of Surgery, Harvard Med. Schl., Director, Nutrition Support Service, New England Deaconess Hospital, Chief of Nutrition/Metabolism Lab, Cancer Research Institute, New England Deaconess Hospital.

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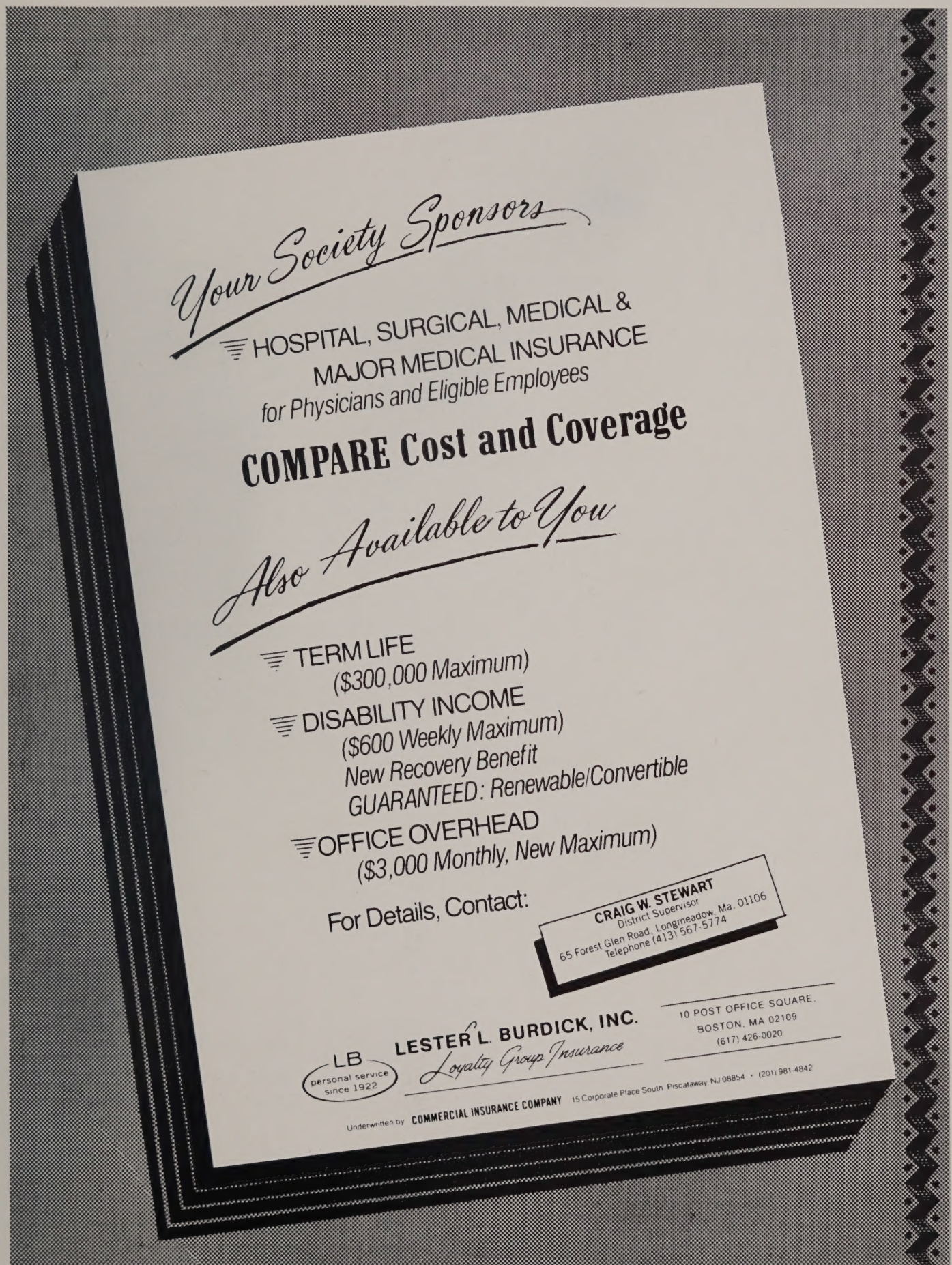
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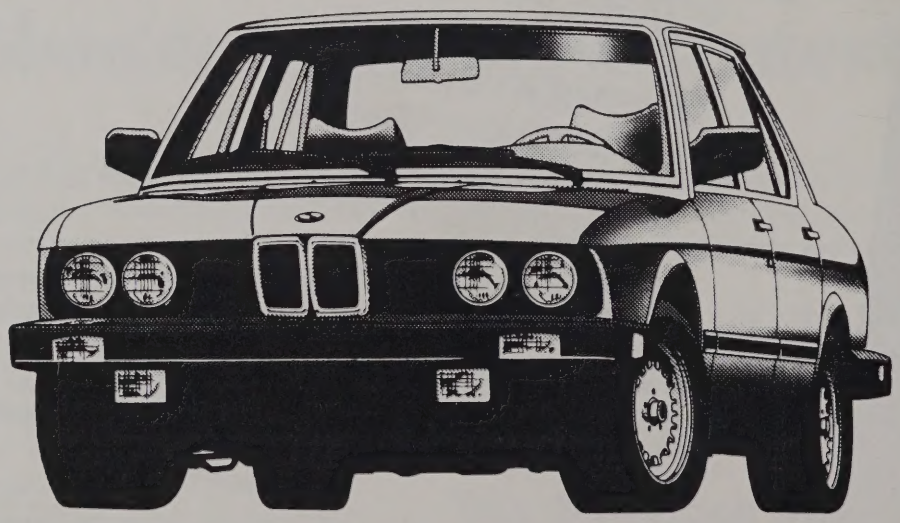

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